Application submission date:

State of Michigan

Child Development and Care (CDC) Program Application

PURPOSE: This is the Michigan Child Development and Care (CDC) Application used to apply for child care assistance. You may be eligible to get help for your child care expenses if you need to work, complete your education or training, or complete treatment activities. Additional information on the CDC program, including income requirements, benefits, and providers can be found at: www.michigan.gov/childcare

YOU CAN QUALIFY FOR CHILD CARE ASSISTANCE IF YOU ARE:

- A family with low income.
- A licensed foster parent requesting care for foster children.
- A member of a Department of Health and Human Services (MDHHS) protective services case participating in a treatment plan.
- A FIP/Extended Family Independence Program (EFIP) or Supplemental Security Income (SSI) recipient.
- A FIP applicant doing a required work participation program activity.

APPLICATION INSTRUCTIONS:

Please complete each step below. The application can also be used as an electronic form that you can complete on your computer and print out. If you need help with reading, writing, or hearing, or have other special needs, please tell us by contacting your local MDHHS office. If you need an interpreter, we may be able to help you.

- ☐ Read all instructions carefully and answer **all** questions in the application completely. If the question does not apply to you, mark it with "NA" (not applicable). **You must answer all of the questions before your application can be processed**.
- ☐ If you need more room, print the file named "CDC Application- Additional Space" and include that with this application. The file can be found at: www.michigan.gov/childcare
- ☐ Provide proof of all the information requested in this application. A list of acceptable forms of proofs can be found at www.michigan.gov/childcare. Copies of original documents should be sent in with this application. **Do not send in original documents**, you may not receive them back. Information includes:
  - ☐ Proof of identification for each adult and child in your family. Please note that you do not have to provide your Social Security Number (SSN). However, it can be helpful for the eligibility process.
  - ☐ Proof of your residence.
  - ☐ Proof of your income and employment.
- ☐ Carefully read the "Rights and Acknowledgements" section of this form located on Page 7. Sign and date Page 7.
- ☐ Take the completed application and proofs to your local MDHHS county office or mail, fax or use the online application at www.michigan.gov/mibridges. A list of county offices can be found at: http://www.michigan.gov/MDHHS/0,4562,7-124-5459_5461---,00.html. Get a receipt when you submit your application for your records. You can also mark the date you submitted your application in the box at the top of this page. Keep this page for your records.

The application will be assigned to a MDHHS benefit specialist, who will work with you to gather all the information needed to see if you qualify for CDC benefits. You may receive a request for more information to help us determine your eligibility for the CDC program. It may take up to 45 days for you to hear if you qualify for benefits. More information on the application process can be found at: www.michigan.gov/childcare

The completion of this application does not guarantee you will receive child care assistance. If you qualify for CDC benefits, you will need to select a child care provider for your children. If you need help finding a CDC provider, please visit the following website for a list of available providers: www.GreatStarttoQuality.org

If you have questions about completing this application or have problems getting the information you need, please contact your local MDHHS office.

Turn to the next page to begin the application.

State of Michigan
Child Development and Care (CDC) Program Application

SECTION 1: APPLICANT INFORMATION

Tell us about you and where you live.

☐ Include proof of your identity. A list of acceptable proofs can be found at: www.michigan.gov/childcare

☐ Include proof of your residence. A list of acceptable proofs can be found at: www.michigan.gov/childcare

Last Name	First Name	Middle Name	
Other Names You Might Be Known As	Gender ☐ Male ☐ Female	Birth Date (MM/DD/YYYY)	Social Security # (SSN) (optional)

Check where you live:
☐ House/Apartment/Mobile Home ☐ Homeless ☐ Other (List)

Address

City	State	County	Zip Code

Mailing address (if different from above or PO Box)

City	State	County	Zip Code
Home Phone	Cell Phone	Work Phone	TTY#

What is your preferred spoken language?	What is your preferred written language?	Do you need an interpreter? ☐ Yes ☐ No

Marital Status
☐ Married ☐ Never Married ☐ Divorced ☐ Separated ☐ Widowed

Ethnicity (optional)	Race (optional)
☐ Hispanic/Latino ☐ Non-Hispanic/Latino	☐ Asian ☐ Black or African American ☐ American Indian or Alaska Native – Enter tribe name ☐ Pacific Islander or Native Hawaiian ☐ White

I need child care services for (check all that apply):	I need study time for (check all that apply). Include the # of hours you need weekly.
☐ Work ☐ High School or GED Completion ☐ Education/Training/Employment Preparation ☐ PATH program or other State-approved activity ☐ Treatment for Health or Social Condition (explain):	☐ High School or GED Completion # Hours Weekly: ☐ Education/Training/ Employment Preparation # Hours Weekly:

Have you ever received child care assistance from the CDC program? ☐ Yes ☐ No

If yes, when?	Where? (City)	(County)

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SECTION 2: LIST ALL PERSONS LIVING IN YOUR HOME

Tell us about all the adults living in your home. Fill out the CDC Application- Additional Space sheet if you need extra space. You can find that sheet at: www.michigan.gov/childcare

List all additional adult members of your household. Include family members who do not live with you, but are expected to return to your home. You do not need to list the person applying.

Name (First, Middle, Last):						
Date of Birth	U.S. Citizen? ☐ Yes ☐ No	Gender ☐ M ☐ F	Relationship to you:	SSN (optional)	Receive MDHHS cash assistance? ☐ Yes ☐ No	Receive SSI benefit? ☐ Yes ☐ No
Name (First, Middle, Last):						
Date of Birth	U.S. Citizen? ☐ Yes ☐ No	Gender ☐ M ☐ F	Relationship to you:	SSN (optional)	Receive MDHHS cash assistance? ☐ Yes ☐ No	Receive SSI benefit? ☐ Yes ☐ No
Name (First, Middle, Last):						
Date of Birth	U.S. Citizen? ☐ Yes ☐ No	Gender ☐ M ☐ F	Relationship to you:	SSN (optional)	Receive MDHHS cash assistance? ☐ Yes ☐ No	Receive SSI benefit? ☐ Yes ☐ No

Tell us about all the children living in your home. Fill out the CDC Application- Additional Space sheet if you need extra space. You can find that sheet at: www.michigan.gov/childcare

List all the children in your house.

Children:

☐ List all children under the age of 18 in your home, or who may be returning to your home.

☐ Include proof of each child's age. A list of acceptable proofs can be found at: www.michigan.gov/childcare

Child Name (First, Middle, Last):						
Date of Birth	U.S. Citizen? ☐ Yes ☐ No	Gender ☐ M ☐ F	Relationship to you:	SSN (optional)	Receive MDHHS cash assistance? ☐ Yes ☐ No	Receive SSI benefit? ☐ Yes ☐ No
Parent Name	Living at home with child? ☐ Yes ☐ No	If no, who does the child live with?	Address, if different?		Parent's Status: ☐ Married ☐ Military ☐ Divorced ☐ Deceased ☐ Separated ☐ Absent for other reason ☐ In Prison	
Parent Name	Living at home with child? ☐ Yes ☐ No	If no, who does the child live with?	Address, if different?		Parent's Status: ☐ Married ☐ Military ☐ Divorced ☐ Deceased ☐ Separated ☐ Absent for other reason ☐ In Prison	
Does child receive child support? ☐ Yes ☐ No		If YES, from whom? ☐ Father ☐ Mother	Who receives the child support?		How much support is received each month? $	
Does the child need child care? ☐ Yes ☐ No		Provider Name			Provider ID(if known)	

Continue to Next Page.

SECTION 2 (Continued):

Child Name (First, Middle, Last):						
Date of Birth	U.S. Citizen? ☐ Yes ☐ No	Gender ☐ M ☐ F	Relationship to you:	SSN (optional)	Receive MDHHS cash assistance? ☐ Yes ☐ No	Receive SSI benefit? ☐ Yes ☐ No

Parent Name, if different than Child above	Living at home with child? ☐ Yes ☐ No	If no, who does the child live with?	Address, if different than Child above	Parent's Status: ☐ Married ☐ Military ☐ Divorced ☐ Deceased ☐ Separated ☐ Absent for other reason ☐ In Prison
Parent Name, if different than Child above	Living at home with child? ☐ Yes ☐ No	If no, who does the child live with?	Address, if different than Child above	Parent's Status: ☐ Married ☐ Military ☐ Divorced ☐ Deceased ☐ Separated ☐ Absent for other reason ☐ In Prison

Does child receive child support? ☐ Yes ☐ No	If YES, from whom? ☐ Father ☐ Mother	Who receives the child support?	How much support is received each month? $
Does the child need child care? ☐ Yes ☐ No	Provider Name		Provider ID (if known)

Child Name (First, Middle, Last):						
Date of Birth	U.S. Citizen? ☐ Yes ☐ No	Gender ☐ M ☐ F	Relationship to you:	SSN (optional)	Receive MDHHS cash assistance? ☐ Yes ☐ No	Receive SSI benefit? ☐ Yes ☐ No

Parent Name, if different than Child above	Living at home with child? ☐ Yes ☐ No	If no, who does the child live with?	Address, if different than Child above	Parent's Status: ☐ Married ☐ Military ☐ Divorced ☐ Deceased ☐ Separated ☐ Absent for other reason ☐ In Prison
Parent Name, if different than Child above	Living at home with child? ☐ Yes ☐ No	If no, who does the child live with?	Address, if different than in Child above	Parent's Status: ☐ Married ☐ Military ☐ Divorced ☐ Deceased ☐ Separated ☐ Absent for other reason ☐ In Prison

Does child receive child support? ☐ Yes ☐ No	If YES, from whom? ☐ Father ☐ Mother	Who receives the child support?	How much support is received each month? $
Does the child need child care? ☐ Yes ☐ No	Provider Name		Provider ID (if known)

SECTION 3: OTHER INFORMATION (Check all that apply)

☐ I am a foster parent requesting child care for a foster child or foster children.
☐ I only need child care to participate in an activity required by MDHHS Protective Services.

SECTION 4: INCOME INFORMATION (Complete subsections A-C below)

Continue to Next Page.

SECTION 4.A: EMPLOYMENT INCOME (Wages)

List all income for you and members living in your house. Fill out the CDC Application- Additional Space sheet if you need extra space. You can find that sheet at: www.michigan.gov/childcare
Attach copies of proofs below to the application.
☐ Proof of work schedule and all income for the most current 30 days, such as wages, tips, commissions and bonuses. A list of acceptable proofs can be found at: www.michigan.gov/childcare

Person Employed	Employer Name	Job Title/Type of Work
Employer's Address	Work Telephone #	Will employment continue? ☐ Yes ☐ No
If new job, first date of paycheck:	Day of week pay is received:	Most recent paycheck date:
Work Schedule Sunday (AM/PM) Monday (AM/PM) Tuesday (AM/PM) Wednesday (AM/PM) Thursday (AM/PM) Friday (AM/PM) Saturday (AM/PM)		Average # of hours expected to work: # Hours Per Total Monthly Income $
Rate of pay $ ☐ Hourly ☐ Salary ☐ Other _____	How often are you paid? ☐ Daily ☐ Weekly ☐ Every Two Weeks ☐ Twice Monthly ☐ Other	Do you receive a bonus or commission? ☐ Bonus ☐ Commission If YES, how much?
Do you work overtime? ☐ Yes ☐ No How often?	Do you receive extra tips? ☐ Yes ☐ No If YES, average tips $ Per ☐ Shift ☐ Week	

Person Employed	Employer Name	Job Title/Type of Work
Employer's Address	Work Telephone #	Will employment continue? ☐ Yes ☐ No
If new job, first date of paycheck:	Day of week pay is received:	Most recent paycheck date:
Work Schedule Sunday (AM/PM) Monday (AM/PM) Tuesday (AM/PM) Wednesday (AM/PM) Thursday (AM/PM) Friday (AM/PM) Saturday (AM/PM)		Average # of hours expected to work: # Hours Per Total Monthly Income $
Rate of pay $ ☐ Hourly ☐ Salary ☐ Other _____	How often are you paid? ☐ Daily ☐ Weekly ☐ Every Two Weeks ☐ Twice Monthly ☐ Other	Do you receive a bonus or commission? ☐ Bonus ☐ Commission If YES, how much?
Do you work overtime? ☐ Yes ☐ No How often?	Do you receive extra tips? ☐ Yes ☐ No If YES, average tips $ Per ☐ Shift ☐ Week	

SECTION 4.B: SELF-EMPLOYMENT

Complete this section if you or someone in your house is self-employed.
Examples of self-employment income include product sales, real estate sales, personal services, farming, in-home child care, and rental property. Attach copies of proofs below to the application:
☐ All self-employment income and expenses, such as federal tax returns or business ledgers. A list of acceptable proofs can be found at: www.michigan.gov/childcare

Continue to Next Page.

SECTION 4.B: SELF-EMPLOYMENT (Continued)

Person Employed	Business Name	Type of Work	
Business Address	Business Phone #	Start Date	Date of last paycheck
Estimated hours of self-employment work per day? Sunday Monday Tuesday Wednesday Thursday Friday Saturday		Total Monthly Income (Before expenses) $	
Person Employed	Business Name	Type of Work	
Business Address	Business Phone #	Start Date	Date of last paycheck
Estimated hours of self-employment work per day? Sunday Monday Tuesday Wednesday Thursday Friday Saturday		Total Monthly Income (Before expenses) $	

SECTION 4.C: UNEARNED INCOME

Income Type	Name of Person Receiving	How often received?	Amount	Expected to continue?	Date expecting (if not receiving now)
☐ Money from friends or relatives, etc.			$		
☐ Social Security benefits			$		
☐ Unemployment compensation			$		
☐ State Disability Assistance (SDA)			$		
☐ Pension/retirement benefits			$		
☐ Worker's compensation			$		
☐ Child support			$		
☐ Education grants or loans			$		
☐ Gaming distribution (lottery)			$		
☐ Income/payments from a tribe (tribal GA, land claims, casino profit sharing, etc.)			$		
☐ Housing assistance			$		
☐ Disability benefits			$		
☐ Crops and farm income			$		
☐ Veteran's benefits			$		
☐ Military allotments			$		
☐ Land contract, mortgage or rental income Name of tenant:			$		
☐ Other			$		

Continue to Next Page.

SECTION 6: RIGHTS, ACKNOWLEDGEMENTS, AND SIGNATURE

By signing, you agree to the following:

1. **APPLICATION**: I understand that I have the right to file an application at any time, including prior to any meeting with MDHHS. My application must be approved or denied within 45 days from when it is received by the MDHHS.
2. **NON-DISCRIMINATION**: I understand that if I believe I have been discriminated against because of race, sex, religion, age, national origin, color, height, weight, marital status, sexual orientation, gender identity, handicap, or political beliefs, I have the right to file a complaint with the Secretary, Department of Health and Human Services in Washington, D.C.
3. **PROGRAM BENEFITS**: I understand that my child or children must be approved for the CDC program before I will receive assistance with child care expenses. I am responsible for all child care expenses that are not paid by the CDC program, including child care expenses collected while my eligibility for the CDC program is being determined.
4. **REPORTING REQUIREMENTS**: I understand that I need to report the following changes within 10 work days to my MDHHS specialist:
   - Change in providers or child care setting
   - Residence
   - Household members
   - When the program group's income exceeds the eligibility income scale for the family size
   - I understand that if I do not report these changes, or make false or misleading statements, I can be prosecuted for fraud or perjury.
   - If I report a change that results in my benefits being reduced, the reduction may occur before I am notified.
   - I will contact my MDHHS specialist if I have any questions about whether to report a change.
5. **REPAYMENT OF BENEFITS**: I understand if my provider or I are overpaid by the Department for any reason, the extra money will have to be repaid. If I or someone representing me intentionally provides information that results in an overpayment, I could be prosecuted for fraud.
6. **PROGRAM PENALTIES**: I understand that if I violate any of the program rules, I may be disqualified from the program for six (6) months, 12 months, or a lifetime.
7. **HEARINGS**: I understand that if I do not agree with any decision made on any matter concerning my case, I have the right to ask for an Administrative Hearing. To request information about an Administrative Hearing, I can call my local MDHHS office, or send a written request for an Administrative Hearing to my local MDHHS office.
8. **AFFIDAVIT**: I swear that all the information I have written on this form or told to a MDHHS specialist is true. I understand that I can be prosecuted for perjury if I have intentionally given false information. I also know that I may be asked to show proof of any information I have given. If I have intentionally left out any information or given false information that causes me to receive benefits I am not entitled to, or more benefits than I am entitled to, I understand that I can be prosecuted for fraud.
9. **RELEASE OF INFORMATION**: I authorize the Department to provide information to my child care provider(s) if I am approved for CDC services, when there are changes in my case information previously given to the provider, or when my application for CDC program is denied, withdrawn, or closed. I also authorize MDHHS or any child care provider that may provide care for my child(ren) to release information necessary to determine my right to benefits under any other local, state or federal program. I authorize the Social Security Administration to give the Department all information necessary to determine my eligibility for the CDC program.
10. **COMPUTER CROSS-CHECKING**: I understand that the Department may check with federal, state and private agencies to make sure the information I provide on this application is correct. This may include check wages, income, unemployment benefits, income tax refunds, Social Security benefits and numbers, immigration status, etc.
11. **CDC PROVIDERS**: The child care I select must be provided in Michigan by either a licensed child care center, licensed group child care home, registered family child care home, an enrolled unlicensed provider who provides care in the home where the child lives, or a family member of the child and who provides the care in his/her home.
    - I understand that my provider is not employed by the State of Michigan. My provider receives a payment that is issued on my behalf by the MDHHS.
    - If I choose an unlicensed provider, he or she will not be enrolled in the CDC program or will not receive payment:
      - If he or she, or any adult reported as living in the provider's home, is on the central registry as a perpetrator on a substantiated Children's Protective Services case or has been charged or convicted of certain disqualifying crimes.
      - If he or she has not completed the Basic Training requirement (referred to as the Great Start to Quality Orientation). Any care provided prior to his/her their training date will be not paid by the State of Michigan.
12. **Review:** My records may be selected for review. If selected, a State of Michigan representative might call me and other people in order to verify my eligibility for the CDC program.

SIGNATURE: I HAVE READ AND UNDERSTAND ALL PARTS OF THIS FORM.

Signature of applicant or representative	Date of signature	Telephone #
Signature of Witness		Date of signature

Department of Health and Human Services (MDHHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a MDHHS office in your area.	This form is issued under authority of Public Act 280 of 1939. Completion of this form is voluntary. However, if it is not completed, your eligibility cannot be determined and you will not receive child care services.

For additional assistance, please contact your local MDHHS Office